Reset Form

PHYSICAL EXAMINATION REPORT FOR BOXER OR MIXED MARTIAL ARTIST OR MARTIAL ARTIST

State Form 54475 (R3 / 6/25)
INDIANA GAMING COMMISSION

INSTRUCTIONS: Examinations can be e-mailed to iac@igc.in.gov, faxed to (317) 233-0047, or mailed to:
Indiana Gaming Commission
Attention: Athletic Division
101 W. Washington Street
East Tower, Suite 1600
Indianapolis, Indiana 46204

FIGHTER INFORMATION
(*To be completed by fighter.*)

Full name of applicant (*first, middle, last*)	Date of birth (*month, day, year*)

Address (*number and street, city, state, and ZIP code*)

Primary telephone number ( )	Email

Sex	Height	Weight
☐ Male ☐ Female		

MEDICAL HISTORY
(*To be completed by fighter.*)

Has individual ever had any of the following conditions:

☐ Fainting spells	☐ Rupture (hernia)	☐ Chest pains	Operations
☐ Shortness of breath	☐ Swollen joints	☐ Spitting of blood	☐ Diabetes
☐ Frequent headaches	☐ Convulsions (fits)	☐ Chronic cough	☐ Rheumatis
☐ Bleeding disorder	☐ Asthma	☐ Allergies	☐ Double vision
☐ Palpitations (racing heart rate)		☐ Cerebral hemorrhage or any other serious head injury	

Number of knockouts received:_____ Date of last knockout (*month, day, year*): _____

Longest duration of unconsciousness: _____

Length of time before resuming boxing or mixed martial arts after last knockout: _____

Ever knocked unconscious in another sport or in any other way? Yes ☐ No ☐
If yes, explain:

Amateur boxing record	Wins_____	Losses_____	Draws_____
Professional boxing record	Wins_____	Losses_____	Draws_____
Bare-Knuckle record	Wins_____	Losses_____	Draws_____
Amateur Mixed martial arts record	Wins_____	Losses_____	Draws_____
Professional Mixed martial arts record	Wins_____	Losses_____	Draws_____
Amateur Martial arts record	Wins_____	Losses_____	Draws_____
Professional Martial arts record	Wins_____	Losses_____	Draws_____

AFFIRMATION
(*To be completed by fighter.*)

I hereby swear or affirm, under penalties of perjury, that the statements made in this report are true, complete, and correct.

Signature of fighter	Printed name of fighter	Date (*month, day, year*)

PHYSICAL EXAMINATION
(*To be completed by examining physician.*)

Pulse at rest:_____ Pulse after 100 hops: _____

Blood pressure at rest:_____ Blood pressure after 100 hops: _____

Glands
Enlarged? ☐ Yes ☐ No Goiter ☐ Yes ☐ No

Heart
Pulse rhythm ☐ Regular ☐ Irregular Apical Impulse ☐ Heavy ☐ Normal
Enlargement? ☐ Yes ☐ No Murmurs? ☐ Yes ☐ No

Lungs
Rales? ☐ Yes ☐ No

Breasts
Mass? ☐ Yes ☐ No Tenderness? ☐ Yes ☐ No Discharge? ☐ Yes ☐ No

Abdomen
Enlargement of liver? ☐ Yes ☐ No Enlargement of spleen? ☐ Yes ☐ No
Hernia? ☐ Yes ☐ No If yes: ☐ Femoral ☐ Inguinal ☐ Ventral
Remarks:

Testicles
Normal? ☐ Yes ☐ No
Remarks:

Reflexes
Pupils:_____ Knee jerks:_____ Romberg:_____ Babinski: _____

Skin
Rash:_____ Boils:_____ Any other unhealed wounds: _____

Remarks for specified medical clearances:

Medications:

Physician MUST check one of the boxes below:

☐ **I HAVE** ☐ **I HAVE NOT**

Medically cleared this fighter to compete in combat

Physician Stamp:

Physician's signature	Physician's name and license number	Date (*month, day, year*)

Physician's business address (*number and street, city, state, and ZIP code*)	Business telephone number ( )	Business fax number ( )